THE CONTRIBUTION OF QUALITATIVE METHODS TO UNDERSTANDING A COMPLEX HOUSING INTERVENTION FOR ADULTS EXPERIENCING HOMELESSNESS AND MENTAL ILLNESS

by

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ABSTRACT

This paper documents the contribution of qualitative methods to a multi-site randomized controlled trial – the *At Home* project. The objectives of the Vancouver *At Home* project are to examine the housing and support needs of people experiencing homelessness and mental illness and, based on these needs, facilitate the development of more effective and efficient policies and services. This paper examines a subset of the qualitative component, focusing on a preliminary analysis of eight baseline personal narrative interviews. These partial interviews (High, Low and Turning Points) were coded for redemptive experiences, contamination scenes and dominant themes. Three of eight participants discussed redemptive experiences and three participants contaminated scenes that were initially positive. These findings, as well as the broader contribution of qualitative research to a randomized controlled trial, are discussed within a social justice framework and illustrate the necessity of utilizing multiple methods to maximize the validity of the resultant policy recommendations.

Keywords: homelessness; narrative; qualitative methods; social justice

For M.L., 1961 – 2010.

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1: INTRODUCTION

It has been over 120 years since *New York Tribune* reporter Jacob Riis (1890), wrote the story “How the Other Half Live”, shocking many middle and upper class citizens with his narrative and accompanying photos depicting the lives of the poor living in New York City – lives characterized by a lack of employment, hunger and homelessness. As a social reformer, Riis argued that to be housed is a human right, and that when charitable citizens saw “how the other half lived” they would be “roused from their lethargy”, with the realization that all citizens are benefactors of a flourishing community. Riis’ findings led to a policy sea change, resulting in regulation of the tenements where the poor lived, thereby substantially improving living conditions for local residents. This seminal work greatly influenced not only common understandings of the importance of housing and the plight of those who are marginalized within society, but also illustrates how the mix of quantitative and qualitative data provides a useful method for shaping social action around homelessness.

In the last twenty years, there has been increasing recognition in the social and natural sciences that a “mix of qualitative and quantitative methods can maximize the research endeavour” (Nastasi & Schensul, 2005, p. 178). Similarly, within the domain of mixed methods research, complex interventions are becoming more frequent. The United Kingdom Medical Research Council defines a complex intervention as “an inquiry comprising a number of separate elements which seem essential to the proper functioning of the intervention, although the ‘active ingredient’ of the intervention that is effective is difficult to specify” (Medical Research Council, 2000, p. 1). Within health services research, recent reviews have found that, although this type of intervention research is becoming more frequent, the specific combination of a qualitative study alongside a randomized controlled trial (RCT) is not yet common, the findings from the qualitative studies are often poorly integrated with corresponding quantitative data, and many studies have significant methodological shortcomings (Lewin, Glenton & Oxman, 2009).

In Canada, a multi-site complex intervention trial, the *At Home* project, is currently underway in the form of a qualitative study alongside an RCT to examine the

housing and support needs of people experiencing homelessness and mental illness. The qualitative research component includes a developmental evaluation of project planning and implementation as well as personal story interviews with a subset of participants. It is hoped that the personal narratives will serve to inform decision makers and members of the public about the strengths and perspectives of persons living with homelessness and mental illness (Washington & Moxley, 2008), and provide insight into factors that may contribute to residential stability and recovery. By embracing multiple methods within a single study, the *At Home* project aims to produce rich and detailed portraits of homelessness across Canada, such that subsequent policy recommendations are responsive to the lived experience of these individuals.

This paper pertains to the Vancouver site of the *At Home* project, and explores how the use of qualitative methods alongside an RCT can be used to improve the validity and policy relevance of the research. First, an overview of the public health and societal impact of homelessness is presented, followed by a synopsis of methodological approaches commonly used in homelessness research, with a particular focus on mixed methods. Next, the *At Home* project is described, focusing on the unique contribution the personal narratives of people with lived experience make to determining the effectiveness of supported housing programs. Situated within a social justice framework, and in keeping with the project research design, narrative analysis is used to examine a subset of the first eight personal story interviews conducted with *At Home* participants.

2: BACKGROUND

2.1 Public Health and Societal Impact of Homelessness

Homelessness in Canada has grown in recent years (Gaetz, Tarasuk, Dackner & Kirkpatrick, 2006), with annual street counts in some cities seeing triple-digit increases (Laird, 2007). Growing income inequality, structural changes in the economy, and shifts in government policy have led to cuts in support for low-income individuals and families, reductions in the stock of affordable housing, and a decline in funding for residential and community-based care (Brzozowski, Gervais, Klein, & Suzuki, 2010; Buzzeli, 2009; Gaetz, 2010). Beginning in the 1980s, the shift in federal priority to a market-based housing system brought about a continual decline in the creation of social housing units, which peaked with 25,000 new units per year in 1983 (Hulchanski, 2002). The differential impact of these policies has played a decisive role in perpetuating vulnerability to homelessness for a diverse population of Canadians.

The cost of homelessness is borne collectively, by all citizens (Klein *et al.,* 2008). In a recent review of ten cost-effectiveness studies, Rory (2010) found that from the perspective of the governments of Canada (i.e., budgetary), the cost of living on the streets or in shelters is estimated to be between $35,548 and $47,437 per individual per annum. Similarly, Patterson, Somers, McIntosh, Shiell & Frankish (2008) estimated that, on average, an adult in B.C. who is homeless and has a severe addiction and/or mental illness uses $55,000 per year in health and criminal justice services; when housed with support services, the use of these services drops to $37,000 per person per year. The cost-effectiveness argument is undoubtedly important to policy makers, however, a case can also be made for housing as a social imperative, therefore obligating a shared responsibility for ensuring that resources are distributed in a way that guarantees universal access to housing (Rosenheck, 2000).

For individuals experiencing homelessness, the list of associated health and social consequences is vast (Baggett, O'Connell, Singer & Rigotti, 2010), making the prevention of its onset and mitigating the effects for those currently without shelter an important goal for the well-being of both individuals and communities (Apicello, 2010). The number of Canadians reported to be experiencing homelessness at any given time

is estimated to be as high as 157,000 (Trypuc & Robinson, 2009). In addition, research shows that mental disorders have a higher prevalence among people experiencing chronic homelessness compared to the general population (North, Eyrich, Pollio, & Spitznagel, 2004; Fazel, Khosla, Doll, & Geddes, 2008). Of this subpopulation, numerous individuals also have substance use disorders. For example, in B.C. alone, it is estimated that as many as 15,500 adults with severe addictions and/or mental illness are homeless, and a further 39,000 such individuals are inadequately housed (Patterson *et al.,* 2008).

Apart from mental disorders, numerous health issues are overrepresented in the homeless population. These include, but are not limited to, traumatic brain injury (Hwang *et al.*, 2008), violence and victimization (Kushel *et al*., 2003; Larney, Conroy, Mills, Burns, & Teeson*,* 2009), suicide (Fitzpatrick, Irwin, LaGory, & Ritchey, 2007) substance use disorders (Morse *et al.,* 2006), Hepatitis C (Rustgi, 2007) and tuberculosis and HIV infection (Barnes *et al*., 1996; Zolopa *et al*., 1994). Exacerbating these problems is the fact that people experiencing homelessness often have poor, and unequal, access to healthcare (Baggett *et al.,* 2010). Most striking, are the higher mortality rates (as high as 10-fold risk) in people experiencing chronic homelessness compared to those who are housed (Cheung & Hwang, 2004; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009).

Notwithstanding the seriousness of these health concerns, rates of illness alone paint only a partial picture, as they do not take into account the stigma and discrimination that persons with experiences of homelessness and mental illness endure (Montgomery *et al*., 2008). A recent study by the Centre for Equality Rights in Accommodation (2009) found that when submitting an application to rent an apartment in the city of Toronto, Ontario, those with an identified mental disability had a discrimination rate of 35%, a full 9 percentage points higher than the next most discriminated against group. In addition to stigma and discrimination, the experience of living with homelessness and mental illness behoves us to consider those things that make a house a home – for "a home is not just a physical space: it provides roots, identity, security, a sense of belonging and a place of emotional wellbeing" (The *PLOS Medicine* editors, 2008). These attributes of 'home' are important as they may promote or hinder residential stability and community integration for *At Home* participants. Moreover, such attributes are characteristics shared by not only healthy individuals, but also by healthy communities (Friedli, 2009; Yanos, 2007).

2.2 Conceptual and Methodological Traditions in Homelessness Research

Homelessness research is difficult to conduct due to the transient nature of the population, problems with enumeration and a contested operational definition of homelessness itself (Cronley, 2010). The word *homelessness* has been referred to in the literature as "an odd job word, pressed into service to impose order on a hodgepodge of social dislocation, extreme poverty, seasonal or itinerant work, and unconventional ways of life" (Hopper & Baumohl, 1996, p. 3). In his recent keynote address at the *Growing Home: Housing and Homelessness in Canada* conference held in Calgary in 2009, J. David Hulchanski observed that while the word *homeless* has been used throughout history to describe having no home or permanent abode, only recently has the Oxford English Dictionary updated the definition of the word to include (its regrettable) status as a noun which designates 'homeless people as a class', while there remains no formal definition for *homelessness*. Hulchanski further identified the addition of the suffix –ness as responsible for turning the simple word *homeless* into an abstract concept, thereby heaping all manner of problems into one convenient term. While the majority of societies have, and likely always will have, some people who are homeless, the set of social problems associated with the word *homelessness* have not always existed (Ravenhill, 2008; Springer, 2000).

Over time, societal impressions of homelessness have been derived from a process of social construction, in which groups ascribing to either individual or structural interpretations of social problems have framed definitions and debate around the issue (Cronley, 2010). For example, in the United States, themes of individualism and self-reliance pervade the dominant culture, such that individual responsibility is thought to dictate success or failure (Zinn, 2005). Thus, the capacity to find and keep housing is believed to be a combination of individual-level factors and personal choice, relegating those without homes to deviant status. Gradually, researchers have underscored the interplay among individual and structural factors, in recognition of the fact that a lack of affordable housing stock and reduced opportunities for employment interconnect with vulnerability to create risk of homelessness (Caton *et al.,* 2005).

The bulk of existing research on homelessness originates from the United States, where methodological traditions have been predominantly quantitative, influenced by a positivist worldview (Anderson & Christian, 2003). Defined broadly, positivists hold the view that the social world is constitutionally analogous to the natural world, and that

there is an ‘objective’ truth that can be revealed if practitioners of social science research use appropriate methods and procedures in a sufficiently systematic manner (Creswell, 2009). Principles of positivist (and later post-positivist) research include emulation of the natural sciences as closely as possible, the search for empirical consistencies that can be generalized, and the use of quantitative research methods, with emphasis placed on value-freedom (Creswell, 2009).

In contrast, a large body of research on housing and homelessness stems from Britain, which, while not devoid of positivist underpinnings, has seen inquiry in this area take on an increasingly interpretivist character (Fitzpatrick & Christian, 2006). Interpretivists believe that conscious human agents internally experience reality and their world is socially constructed through interactions with other human agents (Creswell, 2009). Rather than seek out one objective truth, interpretive social science makes inquiry into meaningful social action that has subjective significance to the actors involved, while recognizing that value-freedom and neutrality are neither necessary nor possible (Neuman, 2006). The main emphasis is on discerning social context and social action, and as such, interpretivism as an epistemological orientation is decidedly associated with qualitative research methods (Bryman, Teevan & Bell, 2009).

In Canada, research on homelessness has historically shown a division amid quantitative analyses of prevalence and incidence, and small, detailed analyses of specific subpopulations or issues (Klodawsky, Aubry, Nemiroff, Bonetta & Willis, 2009). A recent review by Frankish, Wong, and Quantz (2005) found that while intervention research designed to decrease homelessness overall and improve the health of people experiencing homelessness is not uncommon in Canada, the vast majority of programs for this population have not undergone evaluation, and there has been limited research investigating the impact of policy on homelessness or quality of life. Additionally, the majority of studies have been cross-sectional, with the use of longitudinal work and incorporation of a comparison group more commonly emerging from the United States. Within the Canadian context there is a dearth of inquiry collecting information on the same participants over time (Klodawsky *et al.,* 2009). This gap is important, as without longitudinal data, it will be difficult to understand pathways into and out of homelessness, as well as the long-term impact of policies and services designed to support this population.

2.3 The Potential of Mixed Methods in the Context of Homelessness Research

In an effort to be more comprehensive, investigators working in the area of homelessness research, as with inquiry in other health services research areas, have recently begun to embrace the use of mixed methods approaches (O'Cathain, Murphy & Nicholl, 2007). Mixed methods research is defined as "an approach to inquiry that combines or associates both qualitative and quantitative forms. It involves philosophical assumptions, the use of qualitative and quantitative approaches, and the mixing of both approaches in a study" (Creswell, 2009, p. 230). As an orientation concerning social inquiry, a mixed methods way of thinking intentionally invites dialogue about multiple ways of understanding phenomena, based on multiple views surrounding what is to be respected and valued (Greene, 2008). Thus, within the context of intervention research, mixed methods approaches can produce full and complementary data that can extend and enhance the phenomenon of interest (Whitley, 2007).

When methods are mixed in complementary ways, several benefits may ensue, ultimately leading to a more thorough analysis (Creswell, Fetters & Ivankova, 2004). For instance, in their study of the use of mixed methods approaches for researching health disparities, Stewart, Makwarimba, Barnfather, Letourneau & Neufeld (2008) identify the following benefits of using this approach: triangulation (convergence or corroboration of findings from different methods studying the same phenomena); attenuating the likelihood of alternative explanations for conclusions and inferences; illustrating divergent features of the issue under investigation; and achieving a more precise and complete view of participants' experiences, with greater equity of voice. Similarly, O'Cathain *et al.* (2007) note that justification of the use of a mixed methods approach need not be based on any ideological stance, but on the impetus to address policy relevant issues in a complex research environment by interacting with the real world. Thus, the desire to incorporate multiple perspectives can be part of an applied and pragmatic approach rather than (or in addition to) being based on an ideology of empowerment of vulnerable groups.

Notwithstanding these justifications and benefits of the use of mixed methods approaches, there are several difficulties that researchers face when undertaking this type of research. The foremost challenge, as identified by Stewart *et al.,* (2008) is "the delineation of qualitative research questions and quantitative questions/hypotheses which are complementary and improve rigor" (p. 1407). To improve rigor, the challenge

of legitimation (or validity) needs to be addressed in this context (Collins, Onwuegbuzie & Jiao, 2007). The challenge of legitimation in mixed methods research refers to "the difficulty in obtaining findings and/or making inferences that are credible, trustworthy, dependable, transferable, and/or confirmable" (Onwuegbuzie & Johnson, 2006, p. 269), and it is more difficult to achieve in multi-method investigations compared to those utilizing one method. This challenge manifests differently amongst quantitative versus qualitative research components. In quantitative research, the importance of validity is well documented in the literature, and includes three traditional forms: content validity (the phenomena being measured are what is claimed to be being measured); predictive or concurrent validity (whether scores predict a criterion measure or correlate with other findings); and construct validity (whether items measure concepts of hypothetical constructs) (Creswell, 2009).

In qualitative research, the issue of legitimation and how to ensure it remains contested (Collins, Onwuegbuzie & Jiao, 2007; Greene, 2008). Qualitative research itself is a diverse field, both within and beyond mixed methods approaches. Notwithstanding the diversity of approaches and techniques within the realm of qualitative inquiry, a recent review pertaining to health care found seven fundamental criteria for good qualitative research, of which the first four are widely agreed upon and the remaining three involve divergent perspectives dependent on the particular paradigm (e.g., interpretivist or realist) ascribed to by the authors (Cohen & Crabtree, 2008). These criteria are listed in Table 1, with descriptions of how they have been applied in the Vancouver *At Home* project.

Understanding the concept of legitimation (or validity) within this context necessitates comprehending beliefs held about the nature of reality – as discussed previously, whether one believes that there is one or multiple realities that can be observed will impact the rendering of the realities studied. Within the *At Home* project, and as reflected in Table 1, measures to ensure high quality, rigorous qualitative research are being undertaken, such that we may co-construct a rich and detailed account of experience, with robust evidence for inferences and conclusions. Subsequent reporting of the views of individuals experiencing homelessness and mental illness will reflect their multiple perspectives on social reality, while appreciating that the researcher is entangled in the depiction of this experience.

Table 1. Fundamental Criteria for High Quality Qualitative Research as Understood in the Vancouver At Home Project

Criteria	Description	The *At Home* Project
1. Carrying out ethical research	To conduct ethically sound research one must carry out the research in a way that is respectful, humane and honest – embodying the values of empathy, collaboration and service.	Ethical approval was obtained from both UBC and SFU. The interviewer team receives ongoing training in ethical issues and interviewing skills. Individually and collectively we engage in reflective practice around a variety of issues related to recruitment and interviewing. As ethically sensitive scenarios arise, the research and project teams meet to discuss how best to protect the well-being of participants.
2. Importance of the research	Research is important when it is pragmatically and theoretically useful, and advances the current knowledge base.	No Canadian studies have recruited on the basis of homelessness and mental illness. Longitudinal research is scant and the need for various housing and support services for this population is growing. The *At Home* project is a pragmatic intervention trial using an evidence-based approach to housing and supporting people with severe mental illness who have histories of homelessness.
3. Clarity and coherence of the research report 4. Use of appropriate and rigorous methods	The report itself should be concise and provide a clear and adequate description of the research question, background and contextual material, study design, and rational for methodological choices. Description of the data should be unexaggerated, and the relationship between data and interpretation should be understandable.	Reports have not yet been written, however the rationale for methodological choices is discussed within the present paper. In addition, while conducting the qualitative research, establishing methodological rigor has been a priority (i.e., review of 10% of the audio files to ensure accurate transcription, review of all transcripts to ensure accuracy, multiple coders, and reading through transcripts as a team).
5. Importance of reflexivity or attending to researcher bias[†]	*Interpretivist Perspective*: Views researcher subjectivity as something used actively and creatively through the research process rather than as a problem of bias. Thus, good research would entail understanding and reporting relevant preconceptions through reflexive processing (e.g., journal keeping). *Realist Perspective*: Views researcher bias as a problem affecting the trustworthiness, truthfulness, or validity of the account. In addition to understanding	The role of reflexivity will become increasingly important as we move toward sense-making and interpretation of the qualitative transcripts. Based on an interpretivist perspective, the belief that there are multiple realities and that the interviewer and participant co-create the telling and interpretation of these realities, journal keeping and field notes will be useful in understanding individual biases as well as contextual information. To date, the research team has engaged in discussions

	researchers' motivations and preconceptions, value and rigor are enhanced by controlling bias through techniques to verify and confirm findings.	around how questions are posed (providing our own beliefs/opinions, leading questions, "cheering participants on", probing adequately, using simple language).
6. Importance of establishing validity or credibility[†]	*Interpretivist Perspective*: Hallmarks of high quality qualitative research include producing a rich, substantive account with strong evidence for inferences and conclusions. There are multiple views of reality, and possibly even multiple realities. *Positivist and/or Realist Perspective*: Qualitative research based on this view uses alternative terms for validity: adequacy, trustworthiness, accuracy, and credibility. Emphasis is on striving for truth through the qualitative research process (e.g., by having outside auditors or research participants validate findings). Thus, important dimensions of good quality research would be plausibility and accuracy.	Two peer interviewers are members of the research team and will provide feedback on emerging themes and interpretation. As themes and additional areas of inquiry develop, they will be added to future interviews. Inferences will be supported with specific examples and excerpts from narratives, reflecting participants' multiple views of reality.
7. Importance of verification or reliability[†]	*Interpretivist Perspective*: Verification is a process negotiated between researchers and readers, where researchers are responsible for reporting information so readers can discern for themselves the patterns identified and verify the data, its analysis and interpretation. *Realist Perspective*: Rather than leaving the auditing and confirming role to the reader, steps to establish dependability should be built into the research process to repeat and affirm researchers' observations (using the techniques of member checking, peer review, debriefing and external audits to achieve reliability).	Verification will take place through group review and coding of transcripts (i.e., multiple coders). In addition, verification will occur between researchers and readers, as ample information will be provided such that the reliability of the results is transparent. Debriefing and group review of selected transcripts supports rigorous methods.

Source: Adapted from Cohen & Crabtree, 2008. [†]These 3 criteria are not agreed upon with respect to how they should be applied to qualitative research.

2.4 The "At Home" Study

The *At Home* project is a complex housing intervention trial currently taking place in five cities across Canada: Moncton (NB), Montreal (QC), Toronto (ON), Winnipeg (AB), and

Vancouver (BC). The overall goal of the project is to increase our understanding of what combination of housing and supports best promotes recovery among people who are experiencing homelessness and mental illness. In Vancouver, 500 persons experiencing homelessness and mental illness will be recruited between October 2009 and March 2011 to participate in the study, and will be subsequently followed for a minimum of two years. Participants are referred to the study through outreach, institutional settings and community agencies. Eligibility is determined on the basis of the following criteria, as detailed in Table 2:

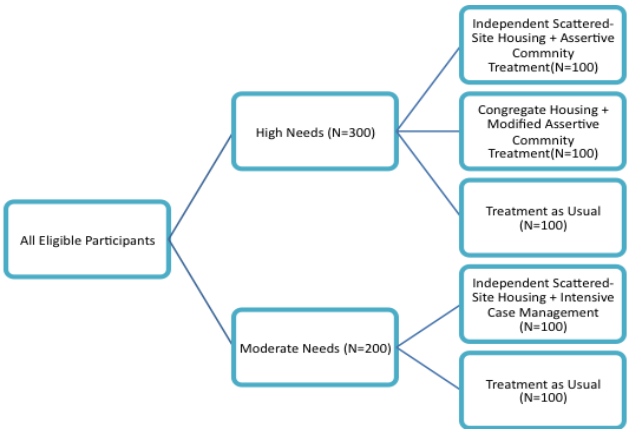
Table 2. Vancouver *At Home* Project Inclusion Criteria

Criteria	Description
Housing	*Absolute homelessness* is defined as having 'no fixed place to stay' for at least the past 7 nights and little likelihood of getting a place in the upcoming month - 'no fixed place to stay' means living rough in a public or private place not ordinarily used as a regular sleeping accommodation for a human being (i.e., outside, on the streets, in parks or on the beach, in doorways, in parked vehicles, squats, or parking garages), as well as those whose primary night-time residence is a supervised public or private emergency accommodation (i.e., shelter, hostel). Those currently being discharged from an institution, prison, jail or hospital with no accommodation are also considered Absolutely Homeless (and eligible) if they have a history of absolute homelessness prior to admission/incarceration. *Precariously housed* is defined as having an SRO, rooming house, or hotel/motel as a primary residence, and 2 or more episodes of being Absolutely Homeless in the past year OR 1 episode of being Absolutely Homeless of at least 4 weeks duration in the past year.
Mental Health Status	*Mental health status* is evaluated using a standardized questionnaire – the MINI Neuropsychiatric Interview. Through administration of the MINI participants are screened for current major depressive disorder, manic/hypomanic episode, panic disorder, posttraumatic stress disorder, alcohol and substance abuse/dependence, and psychotic disorders.
Age	All participants must be over the age of 19 (legal adult status in the province of B.C.).
Participation in an Existing ACT or ICM Program	Participants must not be currently participating in an assertive community treatment program (ACT) or be receiving intensive case management (ICM).

Source: *At Home* Project, Baseline Screener (2010)

Common to all *At Home* sites is a randomization process that includes a comparison of type of housing[1] and corresponding supports with "treatment as usual" (see Figure 1). The study employs a mixed methods design in the form of a qualitative study alongside an RCT to answer a variety of research questions related to effectiveness, costs, recovery, mental health and addiction status, and community integration. An example of a research question related to the personal narratives, as stated in the Request for Proposals is: "Over time, do participants in the *Housing First* programs tell more positive life stories (i.e., stories of redemption/recovery, housing, support, community integration) than those in the usual care group?"

Figure 1. Randomization to Housing Intervention Arm Based on Level of Need (High/Moderate) in the *At Home* Study, Vancouver Site



The qualitative component of the Vancouver *At Home* project will entail conducting fifty personal story interviews with participants at baseline, and again after eighteen months of participation. Ten participants will be selected purposively from one of each of the five study arms (see Figure 1). At baseline, the interviews focus on what life was like before and after participants first become homeless, as well as experiences with homeless services and the mental health system. Finally, participants are asked to describe a high, low and turning point in their lives.

[1] Based on a *Housing First* approach (Tsemberis, Gulcur, & Nakae, 2004) the *At Home* project is centred on consumer choice where persons experiencing homelessness are moved directly from absolute homelessness or precarious housing to their own apartments with support services.

3: PURPOSE OF THE CURRENT INQUIRY

The purpose of this paper was to examine the unique contribution of qualitative data within an RCT to determining the housing and support needs of people experiencing homelessness and mental illness in Vancouver, and to illustrate how this information might support the development of more effective and efficient policies and services.

3.1 Research Questions

The research questions guiding this investigation were:

1. What is the unique contribution of the qualitative research component of the Vancouver *At Home* project to understanding the effectiveness of supported housing programs for people experiencing homelessness and mental illness?
2. If optimized to their fullest potential, how can the use of qualitative methods within the Vancouver *At Home* project be used to improve the validity and policy relevance of the research?

4: METHODS

4.1 Theoretical Framework

Given the population being studied as well as the project goals and design, a social justice framework was used to guide this research. The concept of social justice embeds the research firmly within the discipline of public health and is appropriate given the complexity and inter-relational nature of complex interventions. Current understandings of social justice in population health intervention research are influenced by a growing realization that health education and individually oriented behavioural interventions have historically failed to reach those most in need (Edwards, 2009). The concept of social justice is situated within a broader human rights framework, making it a useful tool to identify and address the underlying determinants of physical and mental health for marginalized individuals, such as people experiencing homelessness and mental illness. A social justice lens serves to examine the distribution of power within society (WHO, 2002). Hence, the United Nations' 1948 Universal Declaration of Human Rights and related instruments aim to ensure that all people have the right to participate in decision-making processes that affect their lives, thus helping to create opportunities for marginalized groups to gain parity, such that their interests are represented, respected and addressed.

The discipline of public health is rooted in the concept of social justice, which has been identified as a principal goal of social and humanitarian progress (Krieger & Birn, 1998; Edwards & MacLean Davidson, 2008; Shiell, 2010). The definition of social justice most commonly used in the literature originates in the work of philosopher John Rawls and has been adapted by the Public Health Agency of Canada (2008) as follows:

> Social justice refers to the concept of a society that gives individuals and groups fair treatment and an equitable share of the benefits of society. In this context, social justice is based on the concept of human rights and equity. Under social justice, all groups and individuals are entitled equally to important rights such as health protection and minimal standards of income. The goal of public health – to minimize preventable death and disability for all – is integral to social justice (p. 14).

Within the realm of public health policy, recent work by Kenny, Sherwin & Baylis (2010) suggests that a *relational* perspective on public health ethics and social justice should be considered such that policy processes are truly fair and inclusive, as well as responsive to structures of systemic inequality. The authors propose that public health ethics must make clear the varied and complex ways in which individuals are connected to groups and build on the need to attend to the interests of communities and populations, as well as individuals. With this approach, actions taken will be both *social and political*, and therefore must heed ways in which patterns of systematic discrimination function in terms of the social justice goals and activities of public health. Taking the concept of social justice one step further than its Rawlsian distributive justice underpinnings (based largely on the fair distribution of *quantifiable* goods) Kenny *et al*. propose that 'relational social justice' additionally involves equitable access to *social* goods such as rights, opportunities for participation, power and dignity (p. 10). For people experiencing homelessness and mental illness, such aims challenge policy-makers and practitioners to look beyond individual factors and see how members of these social groups may be collectively affected by practices that create or intensify inequalities and social exclusion.

4.2 Methodological Approach

Narrative research is an approach to studying the conditions of socially constructed life, in which one or more individuals are asked to provide personal stories (Creswell, 2009), thereby utilizing language as a vehicle to reflect meanings, which are understood as the foundation of reality (Riessman, 1993). As Neuman (2006) has observed, "narratives are how people organize their everyday practice and subjective understandings, and they appear in oral or written texts to express the understandings. It is a quality of lived experience and a form by which people construct their identities and locate themselves in what is happening around them, at the micro and macro levels" (p. 474). In this way, the researcher studies the lives of individuals, and often retells the story, jointly constructing the narrative in a collaborative format that represents the views of both the participant and the researcher (Creswell, 2009).

Narrative *analysis* concerns a group of methods for interpreting texts that have a common storied shape (Reissman, 2008). Akin to other ecological models, narrative

analysis situates human behaviour within a milieu of mutually dependent components (Vanderstaay, 1994). The purpose of narrative analysis is to witness how individuals make sense of happenings in their lives by observing the manner in which they appoint order on the flow of experience (Riesmann, 1993). Themes and patterns are summarized across individuals, but unique stories and ways of interpreting the world can also be maintained. Thus, the use of narrative analysis can elucidate how social process creates meaning and how contextual conditions structure such processes – making it a fitting methodological technique to use when investigating concepts like homelessness that are simultaneously abstract and deeply entrenched in tangible aspects of social structure (Hopper & Baumohl, 1996; Jacobson, 2009).

Accordingly, this paper employed some of the coding procedures of Dr. Dan McAdams of Northwestern University[2] regarding contamination and redemption sequences in the following types of narrated scenes: life story "high points" (peak experiences), life story "low points" (nadir experiences) and life story "turning points" (McAdams, 2008). As per the larger *At Home* project, it is expected that people will tell more positive life stories (with more redemptive scenes) over time, thus, this preliminary analysis provides a descriptive account of the types of stories being told at baseline. In addition, a preliminary thematic analysis was used to ascertain emergent overall themes (Bryman, Teevan & Bell, 2009).

To date, we have conducted twenty-four personal story interviews with ten women and 14 men. Eight of these interviews (5 men, 3 women) were randomly chosen for this preliminary analysis, and one was only partially usable as the participant was too psychotic to tell a coherent story. Semi-structured interviews, which lasted between 60-90 minutes, used open-ended questions to elicit individuals' detailed accounts of their experiences prior to and during homelessness and their understandings of contributors to that experience. Sampling took place purposively, with an equal number of participants being recruited from each of the five study arms. Participants received thirty dollars for their time and contribution, and all interviews were audio-recorded and transcribed verbatim. The research ethics boards at Simon Fraser University and The University of British Columbia approved the research protocol and participants were assured anonymity and provided signed informed consent.

[2] The coding systems for redemption and contamination sequences are available at The School of Education and Social Policy at Northwestern University, IL. http://www.sesp.northwestern.edu/foley/instruments/

The interviewers were three trained university researchers and two experienced peer interviewers. This group met regularly to debrief and discuss the interview questions and responses as the project unfolded. Prior to formal analysis, the first five transcripts underwent assessment by the team to ensure high quality and rigorous methodological standards were being adhered to. We used an iterative process of discussion and reflection while reading the transcripts to assure interviewers were similarly asking questions, avoiding language that was leading, and were probing in an appropriate and consistent manner.

We explored four topic areas through the use of an interview guide: a) pathways into homelessness; b) life on the street or in shelters; c) first experience with mental health issues; and d) high, low, and turning point stories. For this paper, only the high, low, and turning point stories have been analyzed as they provided the greatest opportunity for participants to openly tell a story of their choice. Table 3 provides the guiding questions for the high, low, and turning point questions.

Table 3. High, Low and Turning Point Guiding Questions

High Point Story:
I would like you to reflect on a high point in your life, what you might think of as the best moment of your life. It could be a moment in time or in your life where you experienced very positive feelings, such as joy, excitement, happiness or inner peace. Does an event like this come to mind? Describe it for me in detail. Make sure to tell me what led up to the scene, so that I can understand it in context. What happened? Where and when did it happen? Who was involved? What were you thinking and feeling in the event? Why is it an important event? What impact has this event had on who you are today?
Low Point Story:
Think back over your entire life and try to remember a specific experience or event where you felt really low: it could involve emotions such as deep sadness, fear, strong anxiety, terror, despair, guilt, or shame. You might think of this as the worst moment in your life. Please describe it for me in detail. Again, tell me what led up to the scene, so that I can understand it in context. Where and when did it happen? Who was involved? What happened? What were you thinking and feeling? Why is it an important event? What impact has this event had on who you are today?
Turning Point Story:
In looking back on your life, are there any big "turning points" that come to mind? This could be times when you experienced an important change in your life. IF YES: Please choose one key turning point and describe it in detail. IF NO: Describe a particular time in your life that comes closer than any other as being a turning point - a scene where you changed in some way.

Source: *At Home* Project Consumer Narrative Interviews, Baseline Interview Guide (2010)

Preliminary analysis of the high, low, and turning point stories included several steps. First, coding of transcripts was done line by line to break down the data and identify concepts embedded within individual statements. Using the coding systems

developed for contamination and redemption sequences, I looked for a discernibly “bad” or emotionally negative event or circumstance leading to a discernibly “good” or emotionally positive outcome as evidence of a redemption sequence, or a positive event or state becoming “bad” or negative as evidence of a contamination sequence (Foley Centre for the Study of Lives, 1999; McAdams, 2008). During this process, a large number of codes initially emerged, which were grouped into a smaller number of overarching themes. The eight stories provide a pilot of the methodology for the Vancouver *At Home* project and reveal preliminary insights concerning the experience of homelessness and mental illness. It is recognized that the limitations of this paper – and its core purpose – do not allow for robust thematic analysis.

5: FINDINGS

Of interest for this paper was the telling of high, low and turning point stories from the perspective of people experiencing homelessness and mental illness. While there were diverse scenarios told in relation to life events, all respondents had experiences with the housing and mental health systems and participation in the *At Home* project in common. The role of the study varied for participants, as five of the eight had received housing through the project. The findings are organized into two types of narrative form as they commonly appear in accounts of significant scenes in an individual's life story narrative: contamination scenes and redemption scenes. In addition, emergent themes are described as detailed in the high, low and turning point stories of *At Home* participants.

5.1 Redemption Scenes

Especially negative events are commonly expressed in life story low points and turning points, but they also appear in other areas, including high points. In this preliminary analysis of eight personal narratives, one of the low point stories was redemptive, and two of the turning point stories were redemptive. The following excerpt from a turning point story serves as an example of a redemptive scene:

> Well, when I got my HIV, I found that I had to change my life around. Change the things that I wanted to go for. Me, I'm planning on going back to school to get my grade 12. Not just to prove to my sons that I can do it, but to prove to other people that even at my age, I can – you can succeed. At anything you want.

In this narrative, the author mentions that she had been diagnosed with HIV. Although the author does not explicitly describe the HIV diagnosis with negative feelings, the event itself is generally considered within societal norms as a negative occurrence. As a result there was movement in her story from a

demonstrably negative event to a demonstrably positive one as follows: news of HIV^+ status → reorientation of life goals. The participant chose to reorient her goals in life, thus a positive outcome resulted following the negative news of the HIV positive status. A reorientation of goals in the face of negative news is a form of growth (Stump & Smith, 2008), as evidenced by this participant and her re-prioritization of her life to include emphasis on healthy endeavours.

5.2 Contamination Scenes

In a contamination scene, "that which was good or acceptable becomes contaminated, ruined, undermined, undone or spoiled. Positive affect gives way to negative affect, so that the negativity overwhelms, destroys or erases the effects of the preceding positivity" (Foley Centre for the Study of Lives, 1999:1). This preliminary analysis of eight personal narratives revealed that two of the high point and one of the turning point stories followed a pattern of contamination with negative affect. The following excerpt of a high point story provides an example of a contamination scene:

> Well, I look upon my early professional career and the recognition I started to gain – respect from peers and engineers and management and my relationship with my wife throughout that time – I felt we were kind of untouchable – and so did she. She thought we had a great marriage and a great future. And then I proceeded to, without knowing what I was doing of course, to erode away the foundations that were being built. She had a beautiful career and I was making good money… the lookout for the future was wonderful if you eliminated substance use. But I eroded away all that was good. Good story, huh?

In this narrative the author notes that his early professional career was a time of positivity on many levels. For example, things are going well with his job, he has the respect of his colleagues and he feels the relationship he has with his wife is 'untouchable'. However, while thinking forward, he essentially erases the positivity of the past as follows: respected colleague & strong marriage → substance use and erosion of all that was good. The theme here is one of loss. Loss of respect, loss of his job, loss of his significant other, and although not reflected in this excerpt (detailed elsewhere in his narrative), he also experienced a loss of self-respect.

5.3 Emergent Themes

While each high, low and turning point story was unique, this preliminary analysis revealed some emergent themes. Given the small sample size, only one emergent theme from each of the three types of stories will be discussed. First, from the low point stories, a theme of abusive experiences featured prominently. Second, from the turning point stories, an emergent theme of excitement about current housing options became apparent. Lastly, a theme of status through employment emerged from the high point stories.

5.3.1 Low Point Stories: Experiences of Abuse

One woman encapsulated the pain she endured as a child at the hands of her family in her chosen low point story:

> I got beaten real bad. It was probably the f-word that came out of my mouth that started it because my dad had told me that I was to read a couple of chapters of it, so I told him I guess to fuck off with it and to go read it, and that's how it all started. I didn't know what to think after that, so all I did was get really angry. I was just a little girl – I was only 5 years old. I ripped the bible in half and my dad came in and punched me in the head. And I just cried. That's all I remember. And being put in cold water.

Other low point stories included themes of abuse at the hands of police and mental health professionals, experiences of substance use, isolation and disturbing mental health symptoms, loss of housing, and living in fear of an abusive partner.

5.3.2 Turning Point Stories: Housing with the *At Home* Project

Two participants indicated that receiving a housing assignment through the *At Home* project was a turning point for them (and one participant noted that it was the best thing that ever happened to her, thus describing the experience as a high point):

> A turning point would be, well, I'm hoping to look back upon what's happening now as a turning point, meaning right back from my first

> encounter with forensics in September last year till now. This 6-month period has been a positive… even though I struggle with depression and suicidal thoughts or what have you throughout this time.

This participant was referred to the *At Home* project through the justice system and felt that the connection he had with them precipitated a turning point leading to this positive change in housing status. Additional turning point stories included themes of loss (death of a parent), gaining employment and meeting new people.

5.3.3 High Point Stories: Status and Identity Through Employment

Three of the eight transcripts analyzed contained high point stories that centred on employment as described in the following excerpt:

> My highest point, getting my Class 1 and going on the highway. It was… I never thought I could do it. I didn't think women were allowed. I didn't think I could afford it, and then I met somebody who said that yeah, women could do it, and it didn't cost all that much money, so I checked into it and uh… I paid a little bit more than I needed to, only because I knew somebody else who knew a truck driver who got me out there and helped me with my class 5. I put in a thousand hours of driving before I ever hit the classroom for my air brakes certificate. I had my class 5 for a month before I went and got my class 1 which covers my class 5.

Additional high point stories included themes of childbirth, receipt of housing through the *At Home* project and connection to nature.

6: DISCUSSION

The findings of this paper support the assertion that the qualitative component of the Vancouver *At Home* project offers unique contributions to understanding how supported housing programs for people with experiences of homelessness and mental illness might be effective. Comprehending how people construct stories to make sense of suffering and various life events was explored through personal narratives as told by *At Home* participants, and this is precisely the type of data that exclusively quantitative methods do not produce. The use of multiple methods enhances the potential of the *At Home* project to make evidence-based policy recommendations, as a more comprehensive understanding of the multifarious nature of homelessness is obtained by exploring multiple ways of knowing (Greene, 2008).

Through preliminary analysis of the narratives of a subset of *At Home* participants, it was revealed that several participants turned high point stories into contaminated scenes. However, three stories were redemptive, suggesting that people experiencing homelessness and mental illness can experience growth from negative setbacks. As documented by McAdams (2008), several studies have shown that redemptive narratives of the self contribute to psychological health and well-being. Similarly, in their study of posttraumatic growth and substance use in homeless women with histories of traumatic experience, Stump & Smith (2008) found that more current substance use was related to less posttraumatic growth – where posttraumatic growth pertains to the experience of positive change in oneself or one's life subsequent to trauma.

With respect to residential stability and recovery, two possible measures of success in the *At Home* program, it might be hypothesized that individuals who tell redemptive stories will fare better in their respective housing scenarios than those who tell contaminated stories. This serves as an example of the unique value of the qualitative component: it can be utilized to suggest new questions that need to be asked, or it could explain process factors that either support or hinder participants' success in the project.

Classical RCTs are commonly acknowledged as the gold standard for satisfying questions of efficacy, but have limitations, especially when applied to complex social issues such as homelessness and related policies (Verhoef *et al.,* 2005). Within the realm of complex interventions, the standardized processes required in RCTs may not be feasible, or appropriate given that such studies commonly rely on principles unique to local contexts, political environments and geographies (Hawe, Shiell & Riley, 2004). For instance, in an investigation such as the *At Home* project, the individualized treatment and support services offered to participants regarding their mental health needs may contradict the necessity for standardized interventions to be delivered within a RCT design. Randomization may also be a problem, as change and measurable recovery processes may depend on the willingness and readiness of the participants to engage with project team members. These issues add to the complexity of a complex intervention, and provide additional justification for the use of a mixed methods approach to answer the same research questions.

Reflecting on the definition of a complex intervention in relation to homelessness research, it is evident that the use of mixed methods attends to the multidimensionality of social reality. Within the context of the *At Home* project, the intricacy of the concept of 'recovery' – it's multi-faceted nature including both objective (residential stability, cost effectiveness) and subjective (quality of life, community integration, social inclusion) characteristics – cannot be wholly summarized in numbers and indicators and consequently such numbers and indicators do not provide a satisfactory basis for policy and action. Rather, the nature and impact of homelessness and mental illness, as well as an individual's ability to 'recover' can only be adequately represented through both quantitative and qualitative data – through both indicators and stories. Only by combining understandings obtained from both of these sources will the validity of the *At Home* project be maximized and the resultant policy recommendations be effectively grounded in, and responsive to, "actually lived social life" (Wasserman, Clair & Wilson, 2009, p. 359).

The findings from this investigation are limited in that they were based on a small sample size and are preliminary in nature. As new data are gathered, emergent themes and the larger conceptual scheme will be improved such that rather than reporting a mere summary of the facts, participants' reflections and interpretations, as revealed in the telling of the high, low and turning point stories, as well as other sections of the interview, will be represented in analyses (Miller, 2000). In addition, next steps include

multiple members of the research team coding the same transcripts to assure consistency and quality in the coding process, focusing equally on areas of agreement as on areas of discordance. Additionally, while mixing of the qualitative and quantitative data can take place in one of three ways (sequential, concurrent, or transformative – see Creswell, 2009), a careful consideration of the use of a social justice lens as a means to advocate for equity for marginalized groups will be suggested.

To conclude, situating homelessness research within the context of social justice identifies why those involved in developing policy responses to both inequity and homelessness need to have relational social justice as an explicit aim. If human rights empower individuals and communities by endowing them with entitlements that foment legal obligations on governments, then the concept of social justice urges the correction of patterns of systemic injustice as experienced by those who are homeless and mentally ill – and other marginalized groups. As a theoretical framework, a social justice perspective enhances the appreciation of experiences of homelessness and mental illness, and serves to increase the policy relevance of the *At Home* findings, such that the structural conditions that generate and perpetuate homelessness can begin to be addressed.

7: CRITICAL REFLECTION

In this critical reflection I consider my role in the research process by examining known biases, assumptions and feelings that I have pertaining to the *At Home* project and homelessness research broadly. I have no first-hand experience of homelessness or mental illness. I am the daughter of a man who has suffered dearly with schizophrenia – it's possible he is experiencing homelessness. I have volunteered with individuals experiencing homelessness and/or mental illness for almost ten years, and am now engaged as a researcher on a large national project that seeks to influence housing policy and the provision of support services for this group. In my role on the project, I initiate relationships through an attitude of empathy and honesty. I have a desire to avoid exploitation of participants, and continue to struggle with whether I will achieve this. In a similar manner, Cloke *et al.* (2000) begin their paper on ethics and reflexivity surrounding researching people with experiences of homelessness with the following quote:

> ... no need to hear your voice when I can talk about you better than you speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Rewriting you, I write myself anew (Hooks, 1990, p. 151–152).

These sentiments rest uneasily with me. Asking people to tell me about their pain is uncomfortable. Delivering the news that someone was not randomized to housing is uncomfortable. Delivering the news that someone *was* randomized to housing is uncomfortable – it's a strange power that I sit guiltily with. My discomfort is meagre in comparison to what participants might feel. As I seek to "learn how to know in order to care" (Cramer, 2009:471) I continue to grapple with these issues. Inherent in the relationship between researcher and researched is the "challenge of reciprocity" (Connolly, 2007) and for me, creating meaningful relationships and outputs presents a personal challenge as I strive to contribute to the current knowledge base.

It is in Kenny *et al.'s* (2010) *relational solidarity* that I engage in homelessness research. This type of solidarity reaches beyond the conventional "us" and "them" version of solidarity surrounding identification with a common cause, where the "us" has an advantage commonly defined in opposition to some excluded "Others". Rather, relational solidarity "values interconnections without being steeped in assumptions about commonality or collective identity in contrast to some other group" (p. 10). Thus, in recognition of my position of privilege, and in keeping with relational solidarity as a function of public health, my role in the research process is grounded within public health itself. I view homelessness and the systematic way in which particularly vulnerable members of society are disadvantaged as an immense social injustice. By working in relational solidarity with my colleagues and with individuals who experience the marginalizing effects of homelessness, I hope to contribute to its undoing.

REFERENCE LIST

Anderson, I. (2003). Synthesizing homelessness research: Trends, lessons and prospects. *Journal of Community and Applied Social Psychology, 13,* 197-205.

Anderson, I., & Christian, J. (2003). Causes of homelessness in the UK: A dynamic analysis. *Journal of Community and Applied Social Psychology, 13,* 105-118.

Apicello, J. (2010). A paradigm shift in housing and homeless services: Applying the population and high-risk framework to preventing homelessness. *The Open Health Services and Policy Journal, 3,* 41-52.

Baggett, T.P., O'Connell, J.J., Singer, D.E., Rigotti, N.A. (2010). The unmet health care needs of homeless adults: A national study. *American Journal of Public Health, 100,* 1326-1333.

Bryman, A., Teevan, J.J., & Bell, E. (2009). *Social research methods* (2nd Canadian ed.). Don Mills, Ontario: Oxford University Press.

Brzozowski, M., Gervais, M., Klein, P., & Suzuki, M. (2010). Consumption, income, and wealth inequality in Canada. *Review of Economics Dynamics, 13*, 52-75.

Buzzeli, M. (2009). Is it possible to measure the value of social housing? Canadian Policy Research Networks. Retrieved from http://www.shscorp.ca/shscnew/content/research/papers/Value_of_Social_Housing_a.pdf

Barnes, P.F., el-Hajj, H., Preston-Martin, S., Cave, M.D., Jones, B.E., Otaya, M., et al. (1996). Transmission of tuberculosis among the urban homeless. *Journal of the American Medical Association, 275*, 305-307.

Caton, C.L.M., Dominguiz, B., Schnazer, B., Hasin, D.S., Shrout, P.E., Felix, A. *et al.* (2005). Risk factors for long-term homelessness: Findings from a longitudinal study of first-time homeless single adults. *American Journal of Public Health, 95*, 1753-1758.

Centre for Equality Rights in Accommodation. (2009). "Sorry it's rented." Measuring discrimination in Toronto's rental housing market. Retrieved from http://www.equalityrights.org/cera/docs/CERAFinalReport.pdf

Cheung, A.M., & Hwang, S.W. (2004). Risk of death among homeless women: A cohort study and review of the literature. *Canadian Medical Association Journal, 170*, 1243-1247.

Cloke, P., Cooke, P., Cursons, J., Milbourne, P., & Widdowfield, R. (2000). Ethics, reflexivity and research: Encounters with homeless people. *Ethics, Place and Environment, 3,* 133-154.

Cohen, D.J., & Crabtree, B.F. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *Annals of Family Medicine, 6*, 331-339.

Collins, K.M.T., Onwuegbuzie, A.J., & Jiao, Q.G. (2007). A mixed methods investigation of mixed methods sampling designs in social and health science research. *Journal of Mixed Methods Research, 1*, 267-294.

Connolly, K. (2007). Introduction to Part 2: Exploring Narrative Inquiry Practices. *Qualitative Inquiry*, *13*, 450 – 453.

Cramer, R.A. (2009). Sharing in community while interviewing "outlaws": Methodological opportunities and challenges. *International Review of Qualitative Research, 1*, 453-480.

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed). Thousand Oaks, CA: Sage.

Creswell, J.W., Fetters, M.D., & Ivankova, N.V. (2004). Designing a mixed methods study in primary care. *Annals of Family Medicine, 2*, 7-12.

Cronley, C. (2010). Unraveling the social construction of homelessness. *Journal of Human Behaviour in the Social Environment, 20,* 319-333.

Edwards, N.C. (2009). Revisiting our social justice roots in population health intervention research. *The Canadian Journal of Public Health, 100,* 405-406.

Edwards, N.C, & MacLean Davidson, C. (2008). Social justice and core competencies for public health: Improving the fit. *Canadian Journal of Public Health, 99*, 130-132.

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLOS Medicine, 5*, e225.

Fitzpatrick, K.M., Irwin, J., LaGory, M., & Ritchey, F. (2007). Just thinking about it: Social capital and suicide ideation among homeless persons. *Journal of Health Psychology, 12,* 750-760.

Fitzpatrick, S., & Christian, J. (2006). Comparing homelessness research in the U.S. and Britain. *European Journal of Housing Policy, 6*, 313-333.

Foley Centre for the Study of Lives (1999). *Coding system for contamination scenes*. Retrieved from http://www.sesp.northwestern.edu/foley/instruments/

Frankish, C.J., Hwang, S.W., & Quantz, D. (2005). Homelesness and health iin Canada: Research lessons and priorities. *The Canadian Journal of Public Health,* 96, s23-s29.

Friedli, L. (2009). Mental health, resilience and inequalities. World Health Organization: Europe. Retrieved from www.euro.who.int/document/e92227.pdf

Gaetz, S., Tarasuk, V., Dackner, N., & Kirkpatrick, S. (2006) "Managing" homeless youth in Toronto: Mismanaging food access & nutritional well-being. *Canadian Review of Social Policy, 58*, 1-19.

Gaetz, S. (2010). The struggle to end homelessness in Canada: How we created the crisis, and how we can end it. *The Open Health Services and Policy Journal, 3,* 21-26.

Greene, J.C. (2008). Is mixed methods social inquiry a distinctive methodology? *Journal of Mixed Methods Research, 2*, 7-22.

Hooks, B. (1990). *Yearning: Race, gender and cultural politics.* Boston, MA: South End.

Hopper, K., & Baumohl, J. (1996). Redefining the cursed word. In J. Baumohl (Ed.), *Homelessness in America* (3-14). Phoenix: Oryx Press.

Hawe P., Shiell, A., & Riley, T. (2004). Complex interventions: How “out of control” can a randomized trial be? *British Medical Journal*, *328*, 1561-1563.

Hulchanski, D. (2002). *Housing policy for tomorrow’s cities*. Canadian Policy Research Networks, discussion paper F/27. Retrieved from http://www.cprn.com/cprn.html

Hulchanski, D. (2009, February). *Homelessness in Canada: Past, present and future.* Keynote address at Growing Home: Housing and Homelessness in Canada, University of Calgary, Calgary, Alberta, Canada. Retrieved from http://www.nhc2009.ca/en/forms/2009_Hulchanski_Homelessness-keynote_Calgary- Conf.pdf

Hwang, S.W., Colantonio, A., Chiu, S., Tolomiczenko, G., Kiss, A., et al. (2008). The effect of traumatic brain injury on the health of homeless people. *Canadian Medical Association Journal, 179*, 779-784.

Hwang, S.W., Wilkins, R., Tjepkema, M., O'Campo, P.J., & Dunn, J.R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *British Medical Journal, 339,* b4036.

Jacobson, N. (2009). Dignity violation in healthcare. *Qualitative Research, 19,* 1536-1547.

Kenny, N.P., Sherwin, S.B., Baylis, F.E. (2010). Re-visioning public health ethics: A relational perspective. *Canadian Journal of Public Health, 101*, 9-11.

Klein, S., Griffin Cohen, M., Garner, T., Ivanova, I., Lee, M., Wallace, B. & Young, M. (2008). *A poverty reduction plan for B.C.* The Canadian Centre for Policy Alternatives. Retrieved from http://www.policyalternatives.ca/projects/economic-security-project

Klodawsky, F., Aubry, T., Nemiroff, R., Bonetta, C., & Willis, A. (2001). A longitudinal approach to research on homelessness. In J.D. Hulchanski, P. Campsie, S.B.Y. Chau, S.W. Hwang, & E. Paradis (Eds), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book, pp. 1-20). Toronto: Cities Centre, University of Toronto. Available at www.homelesshub.ca/FindingHome

Krieger, N., & Birn, A (1998). A vision of social justice as the foundation of public health: Commemorating 150 years of the spirit of 1848. *The American Journal of Public Health, 88,* 1603-1606.

Kushel, M.B., Evans, J.L., Perry, S., Robertson, M.J., & Moss, A.R. (2003). No door to lock: Victimization among homeless and marginally housed persons. *Archives of Internal Medicine, 163,* 2492-2499.

Laird, G. (2007). SHELTER homelessness in a growth economy: Canada's 21st century paradox. Retrieved from http://www.chumirethicsfoundation.ca/files/pdf/SHELTER.pdf

Larney, S., Conroy, E., Mills, K.L., Burns, L., & Teeson, M. (2009). Factors associated with violent victimization among homeless adults in Sydney, Australia. *Australian and New Zealand Journal of Public Health, 33*, 347-351.

Lewin, S., Glenton, C., & Oxman, A.D. (2009). Use of qualitative methods alongside randomized controlled trials of complex healthcare interventions. *British Medical Journal, 339,* b3496.

McAdams, D. (2008). Personal narratives and the life story. In O.P. John, R.W. Robins & L.A. Pervin (Eds.), *Handbook of personality: Theory and research* (3rd ed., pp. 242-262). NY: Guilford Press.

Medical Research Council. (2000). *A framework for developing and evaluation of RCTs for complex interventions to improve health.* Retrieved from http://www.mrc.ac.uk/consumption/idcplg?IdcService=GET_FILE&dID=9025&dDocName=MRC003372&allowInte

Miller, R.L. (2000). *Researching life stories and family histories.* London: Sage.

Montgomery, P., Forchuk, C., Duncan, C., Rose, D., Bailey, P.H., & Veluri, R. (2008). Supported housing programs for persons with serious mental illness in northern communities: A mixed method evaluation. *BMC Health Services Research, 8*, e156.

Morse, G.A., Calsyn, R.J., Klinkenberg, W.D., Helminiak, T.W., Wolff, N., Drake, R.E., … Lemming, M.R. (2006). Treating homeless clients with severe mental illness and substance use disorders: Costs and outcomes. *Community Mental Health Journal, 42,* 377-404.

Suzanne McCudden, B.S.Nastasi, B.K., & Schensul, S.L. (2005). Contributions of qualitative research to the validity of intervention research. *Journal of School Psychology, 43,* 177-195.

Neuman, W.L. (2006). *Social research methods: Qualitative and quantitative approaches* (6th ed.). Boston: Pearson Education Inc.

North, C.S., Eyrich, K.M., Pollio, D.E., & Spitznagel, E.L. (2004). Are rates of psychiatric disorders in the homeless population changing? *American Journal of Public Health, 94*, 103-108.

O'Cathain, A., Murphy, E., & Nicholl, J. (2007). Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study. *BMC Health Services Research, 7*, 1-11.

Onwuegbuzie, A.J. & Johnson, R.B. (2006). The validity issue in mixed research. *Research in the Schools, 13,* 48-63.

Patterson, M., Somers, J., McIntosh, K., Shiell, A., & Frankish, C.J. (2008). *Housing and support for adults with severe addictions and/or mental illness in British Columbia.* The Centre for Applied Research in Mental Health and Addiction. Retrieved from http://www.carmha.ca/publications/all-publications

Ravenhill, M. (2008). *The culture of homelessness.* Burlington,VT: Ashgate Publishing.

Riessman, C.K. (1993). *Narrative analysis.* London: Sage.

Riessman, C.K. (2008). *Narrative methods for the human sciences.* London: Sage.

Riis, J. (2004). *How the other half lives: Studies among the tenements of New York*. New York: Kessinger Publishing.

Rory, A. (2010). *An analysis of policy incentive to encourage private sector investment in affordable rental housing*. Greater Victoria Coalition to End Homelessness. Retrieved from https://dspace.library.uvic.ca:8443/dspace/bitstream/1828/2717/1/allen_rory.pdf

Rosenheck, R. (2000). Cost-effectiveness of services for mentally ill homeless people: The application of research to policy and practice. *American Journal of Psychiatry, 157,* 1563-1570.

Rustgi, V.K. (2007). The epidemiology of hepatitis C infection in the United States. *Journal of Gastroenterology, 42,* 513-521.

Shiell, A. (2010). Market failure is bad for your health but social injustice is worse. *Journal of Public Health, 32*, 12-13.

Springer, S. (2000). Homelessness: a proposal for a global definition and classification. *Habitat International, 24*, 475-484.

Stewart, M., Makwarimba, E., Barnfather, A., Letourneau, N., & Neufeld, A. (2008). Researching reducing health disparities: mixed-methods approaches. *Social Science & Medicine, 66,* 1406-1417.

Stump, M.J., Smith, J.E. (2008). The relationship between posttraumatic growth and substance use in homeless women with histories of traumatic experience. *American Journal of Addictions, 17,* 478-487.

The PLOS Medicine Editors (2008). Homelessness is not just a housing problem. *PLOS Medicine, 12,* e1000003.

The Public Health Association of Canada. (2008). *Core competencies for public health in Canada: Release 1.0.* The Public Health Agency of Canada: Ottawa. Retrieved from www.phac-aspc.gc.ca/core_competencies

Trypuc, B., & Robinson, J. (2009). *Homeless in Canada: A funder's primer in understanding the tragedy on Canada's streets*. Charity Intelligence Canada. Retrieved from http://www.charityintelligence.ca/pdfs/08/download.php?report=Ci-Homeless-in-Canada.pdf

Tsemberis, S., Gulcur, L., Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*, 651-656.

Vanderstaay, S.L. (1994). Stories of (social) distress: Applied narrative analysis of public policy for the homeless. *Journal of Social Distress and the Homeless, 3*, 299-319.

Verhoef, M.J., Lewith, G., Ritenbaugh, C., Boon, H., Fleishman, S., & Leis, A. (2005). Complementary and alternative medicine whole systems research: Beyond identification of inadequacies of the RCT. *Complementary Therapies in Medicine, 13,* 206-212.

Washington, O.G.M., & Moxley, D.P. (2008). Telling my story: From narrative to exhibit in illuminating the lived experience of homelessness among older African American women. *Journal of Health Psychology, 13,* 154-165.

Wasserman, J.A., Clair, J.M., & Wilson, K.L. (2009). Problematics of grounded theory: innovations for developing an increasingly rigorous qualitative method. *Qualitative Research, 9,* 355-381.

Whitley, R. (2007). Mixed methods studies. *Journal of Mental Health, 16*, 697-701.

World Health Organization (2002). 25 questions and answers on health and human rights. *Health and Human Rights Publication Series*, *1,* 1-36. Retrieved from http://whqlibdoc.who.int/hq/2002/9241545690.pdf

Yanos, P.T. (2007). Beyond "Landscapes of Despair": The need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness. *Health & Place, 13,* 672-676.

Zinn, H. (2005). *A people's history of the United States, 1492 to the present.* New York: Harper Perennial Modern Classics.

Zolopa, A.R., Hahn, J.A., Gorter, R., Miranda, J., Wlodarczyk, D., Peterson, J., et al. (1994). HIV and tuberculosis infection in San Francisco's homeless adults: Prevalence and risk factors in a representative sample. *Journal of the American Medical Association, 272*, 455-461.

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